Training Professional Personnel for Mental Health Programs

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Stimulation, not reassurance, was Dr. Lemkau's stated intent in his introductory remarks at the Northeast State Governments Conference on Mental Health, held at Asbury Park, N. J., in March 1956. Dr. Lemkau, director of mental health services of the New York City Community Mental Health Board, pointed out that his paper, somewhat condensed here, served only to introduce 2 days of discussion on mental health. Therefore, he felt that he could risk some statements that might prove arresting. "Perhaps," he said, "I shall only be revealing what I should like to be able to act upon if I were free of the usual restraints on the public administrator."

ADMINISTRATORS of community mental health services are by no means a new breed. They have existed as specialists in mental health programs for many centuries, generally as hospital administrators. In the last 50 or 60 years, outpatient clinic administrators have been added as specialists. Early in their development they were independent of hospitals. More recently outpatient programs have become more closely attached both to general and to mental hospitals. The third phase of the program, prevention and public education, has developed sporadically, but in relatively few places in this country have the three phases been combined under a single administrator.

The lead in making the mental hospital the center of community mental health services appears to come from England where several hospitals and their communities have achieved fame for their extensive community programs. They have established a free flow of patients in and out of hospital and back and forth from the community. The hospital supplies staff for consultation services and outpatient clinics and sees to it that the community is educated to use the services.

This development has seemed more natural in the European system of administration than in the United States, perhaps because medical care and public health have always been closely associated in Europe. In the United States we have developed mental hospital systems independent of general and other specialty hospitals such as the tuberculosis sanatoriums. Health as defined in Europe generally includes mental health; in this country we have tended to think much more of mental health and physical health as independent classes of diseases to be administered by different kinds of specialists. It is probably not accidental that the development of psychobiology came in the United States; perhaps it was less needed, at least at the administrative level, in Europe than here.

On the other hand, in the United States organized public health programs have been reaching toward the ideal of comprehensive medical care and preventive programs. This

has been due in some degree to the control of the epidemic diseases which has left public health with leisure to face the emerging more important causes of death and disability such as cancer, heart diseases, suicide, and the various mental illnesses. Educational and clinical mental health programs within organized public health and vastly increased cooperation, both in personnel training and in planning, administering, and supplying services are rapidly appearing. In a few places, the European plan of grouping together all health services, mental and other, for administration is being tested. I doubt whether there are many people who believe that there should be anything but most cordial cooperation between all segments of health services: mental hospital, specialized hospital, public health services, including education and outpatient services.

Specialization

These trends point to the need for personnel who somehow can envision the whole range of activities of a mental health program, from prevention of brain damage by accident or infection to the care of the chronic case in the hospital. Delineating the sort of personnel required and how they should be trained is not an easy task. Frankly, I do not think the problem has been made less complex by the marked development of multiple professions within the psychiatric service team in the last decades. Frequently, these specialists early become the slaves of the restrictive definitions of their fields. They are almost bound to fail when faced with the problems of the community's total needs rather than that segment of need they, somewhat artificially, have defined as their particular area of specialization. This is no less true of my own profession, psychiatry, than of the rest. How many times have I heard my colleagues protest that they are therapists, usually meaning equipped to deal with neurotic patients, as though that relieved them of responding to the public's need for educators, helpful custodians, rehabilitators, or physiological therapists. I think this attitude is less prevalent now. The ideal of the "compleat" psychiatrist is more frequently an aim of training programs than it was 5 or 10 years ago.

Clinical psychologists are generally careful to distinguish between their field and social psychology. And it is a rare social psychologist who will consent to do more than study a population; he hesitates, frequently, at the threshold of "tinkering" with the forces and situations he does research upon. The clinical psychologist hesitates to act administratively upon the generalizations he frequently draws from his clinical experience, carefully gathering his research cloak around him and passing by on the other side.

Despite the emergence of the ideal of generic training, the social worker has also developed specialization to such an extent that artificial definitions protect him from going all the way in meeting needs of the public. On the other hand, the public health nurse shows a tendency, according to her critics, to respond to needs beyond her professional competence.

How can we remove the polarized lenses from educational procedures and let in to the trainees the full range of light that flows from recognition of the broad range of the public's need? Can this be done in the setting of traditional training patterns or must we develop a new "generalist" in the mental health field? Actually, there is something ludicrous in speaking of any of our present training patterns as traditional. Most of them are less than 50 years old. I am reminded of the college president who announced that on the following day it would become traditional for all male students to appear at chapel in coats and ties.

Shall this broad-visioned planner and administrator be produced by an entirely separate training program, or is it possible for him to be trained through modifications of present training programs? And for the immediate situation, shall the training be additive, on the base of previous specialization, or should it be an entirely new program, starting after the acquisition of the degree in medicine and during the graduate education of the other specialists? And which specialists should be considered as eligible for this training?

When it was my privilege to study with Adolf Meyer, I was struck by the fact that he regarded medicine as basic education and not, as it is for many, terminal education. Had he had his way, all psychologists, sociologists, an-

thropologists, and high-level administrators in any health services, and even in law and public administration generally, would have been trained first in medicine. In my own time, this idea resulted in the education of Norman Cameron, a psychologist now reverted to psychiatric teaching, and Alexander Leighton, a psychiatrist with the added competence in anthropology, among others. Meyer, along with the American Psychiatric Association, never believed that a psychiatric hospital could be as well administered by a nonphysician as by a physician. This did not so much represent a species of professional acquisitiveness as it did a conviction that the discipline and knowledge of medicine were essential to the understanding administration of services to humankind.

In America, medical education has so expanded the basic academic requirements and the length of the medical course itself that the concept of a medical education as a background for other fields has proved largely impractical. On the other hand, medicine, unlike the other disciplines producing workers for the psychiatric team, adds specialty training on top of the degree training; the others tend to specialize and then grant the degree. The psychiatrist starts his training as a specialist only after his medical education is achieved.

Will it be possible to include training for specialties within the medical school and before the degree is gained? Certainly not by present methods which require both practical and theoretical knowledge of the student in all fields of medicine. It might be worth while to place the rotating internship within the 4 years of medical school, but such a plan is not tolerable to the ideals of general medical education at this time. However, the rise of departments of preventive medicine within medical schools has included in the undergraduate medical curriculum a great deal of material about how people live and organize their lives, both health-wise directly, and indirectly, as sociological patterning affects health status. Preventive medicine courses approach more closely than any other in the medical school the additional content needed by the mental health administrator. The courses present, in my estimation, the basic science underlying the specialty of psychogenic psychiatry, though no course including such material has developed in psychiatry departments to my knowledge. The impulse has come largely as an extension of the specialty of public health or of pediatrics as influenced by etiological thinking originating in the specialty of psychiatry. The development of curriculums in preventive medicine, including the observation and medical care of families, opens new challenges to medical students and may whet the appetite of some to accept challenges in program planning and administration in all fields of health, not excluding mental health.

Psychiatric Training

We are emerging from a period of psychiatric training in which the aim has been too exclusively the development of skill in individual psychotherapy. In this period, the psychiatrist's responsibility has been narrowly defined as including only his relationship to the individual patient and his needs. In training centers designed along these conceptual lines, it has been possible for a psychiatrist to finish training with no awareness of the place of the State mental hospital in filling the needs of the community or of the enormous task that confronts these hospitals.

The unrest of Meyer and, later, Harry Stack Sullivan with psychiatric isolationism, plus the war and the training and administrative weight it brought to bear, has largely been responsible for the general abandonment of this exclusively individualistic type of psychiatric training. Karl Menninger has suggested that no psychiatrist should be considered qualified until he has had a year of State hospital experience or its equivalent. This sort of thinking has led to a new status of State hospitals in psychiatric training.

Training in psychiatry in university settings has always included outpatient care, and this has generally forced some study of the community. Too often in the past, however, outpatient treatment has been regarded as an irksome chore, robbing the hospitalized patient of the doctor's time. This pattern, too, is changing with the clearer perception of the outpatient department as a way station between the hospital and the home. Many State hos-

pitals have also developed outpatient services, first, to follow up discharged patients; second, frequently, to meet training requirements; and, too often last, to serve community need. It is surprising how often these clinic arrangements become relatively independent of the hospitals. It is as though the psychiatrist who is responsible for inpatients could not also take care of outpatients. This is, I fear, more often an administrative convenience than evidence of sound planning.

We have seen that medical education is changing and that it may produce physicians more aware of community needs and with more sociological knowledge than it had before. Specialty education of psychiatrists is also focusing more attention on family and community forces in etiology and treatment, and it is recognizing that one person should be able to coordinate the services from education of the public to the rehabilitation of the recovered or recovering patient.

Public Health Instruction

Public health education attempts to keep abreast of the developments in medicine, reducing those with practical application to programs for all the people. There is a growing recognition that mental health is a part of general health and that the techniques and methods available must be applied to this health problem. If present methods are not suitable, new ones must be developed to satisfy the need. Schools of public health, like all other educational institutions, are constantly faced with the issues of how much they are responsible for teaching immediately practical techniques and how much their purpose should be to enlarge the vision of their students so that the blinders of technical skill will not prevent them from seeing the unsolved problems where experimentation and testing, research and application are so necessary. The aim of public health education is to develop competence in comprehensive medical planning and administration; it is not training to furnish services primarily.

It has been frequently suggested that public health training should be required for mental health administrators, that it should be added on top of psychiatric training for those who intend to make a career of mental health administration. In this way the psychiatrist could not escape the broadest possible implications of his task, and he would, in addition, gain technical skill in epidemiology, biostatistics, and public administration. In a very few places, training in schools of public health has been carried out under the supervision of psychiatrists thereby keeping the implications in the mental health field before the student as he learns his basic public health methods. In such instances, some proportion of the public health training may be accredited as psychiatric training.

Some have felt that there is no need for the base in psychiatry, that the public health school ought to be able to see to it that competent administrators of programs are produced without the clinical background. I feel that general medical education is too weak to provide the necessary background of the pathological anatomy and physiology of mental illnesses on which to build. Combined public health and psychiatric training, perhaps replacing the third year of residency training, is much to be desired and should be encouraged for those who are able to catch the vision we have before us.

Related Professions

What of the other psychiatric team professions? Like social work, nursing is turning to the ideal of generic training designed to make every nurse competent on the staff level in public health, psychiatric ward, and operating room functions, among others. Specialist consultants are developed in these fields to keep interest aroused and to promote the functional growth of the nurse. One such specialist, the public health nurse consultant in mental health, has come to the fore in the years since the war. These specialists have the aim of improving the staff level nurses' function in psychiatry and in mental health education and counseling. They are being educated in nursing schools and in public health schools. Evident in the last few years is a movement toward training this specialist in conjunction with those specializing in psychiatric nursing, a movement that makes sense only if the hospital (and the other pro-

fessions concerned) foster the expansion of the function of the psychiatric nurse to include services outside as well as inside the psychiatric ward.

Psychiatric social work, perhaps more than any other profession in the team, has attempted to include the operation of the community and the place of mental health in that operation in its training. It has also included administration in its basic training and in postgraduate courses. Perhaps because of this, psychiatric social workers are proving successful administrators of clinics and, in some places, of the entire program of community mental health. When they rise to positions of leadership of large departments of welfare, they show such sound usage of psychiatric diagnostic and treatment services. Sometimes this opening of doors to the student while in training is followed by a resounding slam by supervision that is too vigorous, too long, and too restrictive after the worker goes into the field. As a result, the range of productive activity is narrower than what the social worker was originally prepared to do. There remains some doubt as to whether the profession of social work can supply personnel for the overall planning and administration of medical services, however. I must admit to the conservative view that such leadership should be sought from the medical school graduate who goes beyond his educational opportunities in medicine to grasp, formally or informally, a view that includes broad public health ideals.

Clinical psychology, too, has broadened its outlook to include much more of community interest and knowledge, though this profession generally appears to have shunned administrative responsibility, allowing the leadership to rest primarily in medical hands.

In each of the professions other than medicine, the structure of training for understanding and manipulating community forces is being included in the undergraduate as well as the postgraduate courses. It remains a moot point whether such inclusions result in a genuine overall public health viewpoint that can provide administrators for mental health programs from the nonmedical field.

A controversial area of mental health work is the responsibility for public education. Should this be done by educators? We have seen the growth of the idea that educational methods are of extreme importance and that they may, in some instances, be almost as important as the content. Furthermore, many other health fields have profited from the use of nonmedical health educators. The professions previously discussed are all concerned with content and primarily individual or small group interrelationships, not with teaching methods to get that content into the minds of the public. What should be taught remains a much more controversial subject in mental health than it is, for example, in nutrition. And many medical and paramedical persons are unwilling to risk putting this decision into the hands of people whose fundamental qualification is in method rather than content.

There is scarcely a statement in this paper so far that cannot be refuted by a successful experiment involving a specific person doing a job outside of his professional competence. As a matter of fact, most of us are doing things for which we were never trained; we have seen an opportunity and grasped it as well as we could. It has often been pointed out that Freud could not qualify as a psychoanalyst since there was no one to analyze him and no institute to qualify him. It behooves us to realize that, however much we may wish to rely on the rather mystical safeguards attributed to special education, every new venture requires people with special vision as well as special training. In new programs it seems to me to be of the utmost importance that we keep civil service requirements as flexible as possible, so that we can hire the "gleam in the eye" as well as the degree on the diploma. This is no easy task.

Conclusions

I would plead that we regard education in the various fields as insurance against foolish and ill-advised experimentation. It cannot be regarded as insurance of productive, creative thinking. In a field so new and varied, flexibility in the use of content and method is as important as knowledge and methodological skill. It is wise to recall that in some people training kills creativeness by narrowing the

range of perceptions the individual can make; such people may be excellent for carrying on jobs for which the ground rules are well known, but they are not useful in facing the newer problems in our field.

Some day mental health work will have a relatively fixed range of content and activity; then education for it may be possible. Meanwhile, one needs only to look at the brief history of the field to see that it is much more dominated by personalities than by solid ideas. So long as this situation exists we shall have to be concerned about an educational program that provides wide knowledge and broad vision as well as technical competence. And our selective processes will use light meters to detect the intensity of the "gleam in the eye" as well as civil service type of requirements.

Mental Health a Hope, Not a State

Mental health is the concept of a hope, not a state. We can collect statistics on mental ills, on tics and ulcers, hallucinations and homicidal impulses, sex crimes, and pathological theft. But we will never have statistics on mental health, for each new question will change the face and the position of the target. The term is used in our culture to indicate our hope of what good may come from a greater knowledge of the way in which men's lives are shaped by childhood experience, by relations with others, and by the forms of the societies in which they live.

The good can take many forms: maternity hospitals organized so infants are not separated from their mothers at birth, children's hospitals in which there are specialists to help a child at the first moment of breakdown, community diagnosticians alert to developing hazards in park or neighborhood and to new needs for association, or places to play, or places where the aged can sit together in the sun. The good can take the form of new ideas of housing in which the need of each individual for privacy will be seen as a matter of mental health rather than of minimum standard of decency and physical health alone. The good may express itself in new standards of ethnic relations or new forms of education which will prevent one sex, or one age, or members of any class from being turned into second-class human beings.

—MARGARET MEAD, Ph.D., *president of the World Federation for Mental Health, addressing the 1957 National Health Forum.*